

PATIENT MANAGEMENT

Intake

PM.1

Written policies and procedures governing the intake process specify at least the following:

PM.1.1 information to be obtained on all applicants or referrals for admission, including the existence of any advance directives for medical care;

PM.1.2 procedures for accepting referrals from outside agencies and organizations;

PM.1.3 records to be kept on all applicants;

PM.1.4 statistical data to be kept on the intake process; and

PM.1.5 procedures to be followed, including alternative referrals when an application is found ineligible for admission.

PM.2

Methods of intake are based on the services provided by the organization and the needs of patients.

PM.3

Criteria for determining the eligibility of patients for admission are clearly stated in writing.

PM.4

The intake procedure includes an initial assessment of the patient.

PM.4.1 Professional staff conduct the intake assessment.

PM.4.2 Intake assessment results are clearly explained to the patient.

PM.4.3 Intake assessment results are clearly explained to the patient's family or legal guardian, when appropriate.

PM.5

Acceptance of a patient for treatment is based on an intake procedure that results in the conclusions described in PM.5.1 through PM.5.3.

PM.5.1 The treatment required by the patient is appropriate to the intensity and restrictions of care provided by the organization or program component.

PM.5.2 The alternatives for less intensive restrictive treatment are not available.

PM.6

The clinical record documents any referral source.

PM.7

During the intake process, every effort is made to assure that applicants understand at least the following information:

PM.7.1 nature and goals of the treatment program;

PM.7.2 hours during which services are available;

PM.7.3 treatment costs to be borne by the patient, if any; and

PM.7.4 the rights and responsibilities of patients, including the rules governing their conduct and the type of infractions that can result in disciplinary action or discharge from the organization.

PM.8

Organizations housing patients overnight have policies and procedures that adequately address at least the following:

PM.8.1 responsibility for medical and dental care, including consent for medical or surgical care and treatment;

PM.8.2 when appropriate, arrangements for family participation in the treatment program;

PM.8.3 arrangements for clothing, allowances, and gifts;

PM.8.4 arrangements regarding departure from the organization or program; and

PM.8.5 arrangements regarding the patient's departure from the organization program against clinical advice.

PM.9

Sufficient information is collected during the intake process to develop a preliminary treatment plan.

PM.10

Staff members who will be working with the patient but who did not participate in the initial assessment are informed about the patient before meeting him/her.

Progress Notes

PM.11

Progress notes are entered in the clinical record.

PM.11.1 Progress notes include the following:

PM.11.1.1 documentation of implementation of the treatment plan;

PM.11.1.2 documentation of all treatment rendered to the patient;

PM.11.1.3 chronological documentation of the patient's clinical course;

PM.11.1.5 description of the patient's response to treatment, the treatment outcome, and the responses of significant others to important events that occur during treatment.

PM.11.2 All entries involving subjective interpretation of the patient's progress are supplemented with a description of the actual behavior observed.

PM.11.3 Efforts are made to secure written progress reports for patients receiving services from outside sources.

PM.11.4 When available, clinical records from outside sources are included in the clinical record.

PM.11.5 The patient's progress and current status in meeting the goals and objectives of his/her treatment plan are regularly recorded in the clinical record.

PM.11.6 The efforts of staff members to help the patient achieve stated goals and objectives are regularly recorded in the clinical record.

PM.11.7 Progress notes are used as the basis for reviewing treatment plans.

PM.11.8 When anesthesia services are provided to patients, the director of anesthesia services is responsible for establishing and monitoring a system for recording all pertinent events that take place during the induction and maintenance of anesthesia and the emergence from anesthesia.

Discharge Summary and Continuing Care

PM.12

A discharge summary is entered in the clinical record within 15 days following discharge.

PM.12.1 The discharge summary includes the results of intake assessment and diagnosis.

PM.12.2 The discharge summary includes a clinical resume that reviews the following;

PM.12.2.1 significant findings;

PM.12.2.2 course and progress of the patient with regard to each identified clinical problem;

PM.12.2.3 clinical course of the patient's treatment;

PM.12.2.4 final assessment, including the general observations and understanding of the patient's condition initially, during treatment, and at discharge;

PM.12.2.5 recommendations and arrangements for further treatment, including prescribed medications and continuing care; and

PM.12.2.6 in organizations serving the severely and chronically mentally ill, documentation of the planning for, and securing of, living arrangements appropriate to the patient's level of functioning is part of the discharge summary.

PM.12.3 The discharge summary includes the final primary and secondary diagnosis.

PM.12.4 A written continuing care plan or referral for continuing treatment, when appropriate, describes the organization's responsibilities for facilitating the transfer of the patient to another phase or modality of the program, to another program, to an agency, to an individual, and/or to the patient's personal support system.

PM.12.4.1 The plan is in accordance with the patient's reassessed needs at the time of transfer.

PM.12.4.2 The plan addresses the need, if any, to coordinate multiple continuing care services after discharge or transfer.

PM.12.4.3 The plan is developed with the participation of the patient and, when indicated, the family, guardian, or significant other(s).

PM.12.4.4 Whenever possible, the plan is implemented in a manner acceptable to the patient and his/her need for confidentiality.

PM.12.5 The efficacy of the discharge plan is evaluated by obtaining information from the accepting program, agency, or individual.

PM.12.5.1 Such information includes, but is not necessarily limited to, the following:

PM.12.5.1.1 whether patient contact occurred as planned; and

PM.12.5.1.2 the appropriateness of the referral, including the capacity of the accepting program to meet the patient's needs.